**DEPARTMENT OF HEALTH & FAMILY SERVICES**
Division of Health Care Financing
HCF 13033 (Rev. 11/02) (formerly known as HCF 1075)

**STATE OF WISCONSIN**
Wisconsin Statutes
Section 859.07

# PROBATE CLAIMS NOTICE

Completion of this form is required according to Wisconsin Statutes ss. 859.07(2), 867.01(3)(d), and 867.02(2)(d). Personal identifying information will only be used in the administration of the Estate Recovery Program and will not be disclosed to other agencies. Failure to complete this form is covered under Wisconsin Statutes ss. 859.02 and 865.17.

| In the Matter of the Estate of: | STATE OF WISCONSIN, Circuit Court Branch |
|---|---|
| Name of Deceased | County |
| Social Security Number | Type of Probate |
| Date of Death | File Number |
| Date of Birth | Final Date to File Claims |

☐ Check here if the Deceased received any of the following:
- Medicaid benefits under s. 49.46 or 49.47, Wis. Stats.;
- Medicaid Community Waiver Program(s) benefits under s. 46.27 through 46.278, Wis. Stats.;
- Medicaid or Non-Medicaid Family Care benefits under s. 46.286, Wis. Stats.;
- Medicaid Purchase Plan (MAPP) benefits under s. 49.472, Wis. Stats.;
- Wisconsin Community Options Program (COP) benefits under s. 46.27, Wis. Stats.;
- Wisconsin Chronic Disease Program (WCDP) benefits under s. 49.68 through 49.685, Wis. Stats.

☐ Check here if a predeceased spouse of the Deceased received any of the following and include his/her name and Social Security Number below (if more than one spouse please attach additional sheet):
- Wisconsin Community Options Program (COP) benefits under s. 46.27, Wis. Stats.;
- Wisconsin Chronic Disease Program (WCDP) benefits under s. 49.68 through 49.685, Wis. Stats.

Name of predeceased Spouse_____ SSN of predeceased Spouse _____

**(Disclosure of Social Security Number of a Medicaid recipient is mandatory per 42 U.S.C. 1320b-7)**

**(Disclosure of Social Security Number of a non-Medicaid recipient is voluntary. The Social Security Number will only be used for the identification of COP and WCDP recipients and for the administration of the Estate Recovery Program)**

| Name of Personal Representative/Petitioner | Mailing Address |
|---|---|
| Name of Attorney | Mailing Address |

*** * * PROOF OF MAILING * * ***

I, _____ being duly sworn on oath certify that on the _____ day of _____ 20

mailed via the U.S. Postal Service, by registered or certified mail, a true and correct copy of this Notice to the State of Wisconsin and to the County Clerk of the decedent's county of residence, and I have filed the original Notice with the Register in Probate for the county listed above as required by ss. 859.07, 867.01, and 867.02, Wis. Stats. They have been mailed as follows:

**Original to:**
Register in Probate
of county listed above

**Copy to:**
STATE OF WISCONSIN
Department of Health and Family Services
Estate Recovery Program Section
P.O. Box 309
Madison, WI 53701-0309

**Copy to:**
COUNTY CLERK
of the decedent's county of residence

Subscribed and sworn to before me

on _____

_____
Notary Public/Court Official

My commission expires _____

_____
Signature

Reset This Form